Metaphors: The Language of Pre and Perinatal Trauma

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Full Text: Headnote ABSTRACT: Verbal metaphors and their behavioral counterparts are discussed within the context of pre and perinatal issues. The major developmental stages are illustrated by the patient's use of language. These metaphors may emerge frequently in casual conversation or during periods of stress throughout life. As an example phrases such as "no way out" express the energy bound in prolonged labor and "being pulled in all directions" is related to a forceps assisted delivery. The baby's reaction to physical and psychological experiences during gestation may be discerned from verbal cues. These symbolic statements offer new possibilities in the realm of diagnosis and psychotherapeutic treatment. Each of us represents ourselves through a variety of behaviors. We project who we are, how we perceive ourselves, and how we want to be viewed through many different forms. The clothing we select projects an image, whether it's the three piece business suit of the executive, the baggy pants and oversized shirt of the rough look, or the elaborate hairdo and rhinestone-studded costumes of Dolly Parton. Our tone of voice, accent, use of words, hand gestures, facial and body language are all symbols that give an additional portrayal of who we are and where we come from. In My Fair Lady, Professor Higgins' point is well taken. Our psychosocial development, our roots, and current history are well represented by our every gesture, our vocal intonation, and the garments we wear. At a deeper level, there are symbols and metaphors that tell an even more critical story. These tales may be blatantly displayed, but unfortunately, their symbolic meaning may go undetected. It has been my experience that whether my patients have a history of neurosis or psychosis, they frequently manifest metaphoric statements both verbally and behaviorally that indicate intrauterine trauma. Problems may originate themselves during conception, pregnancy or delivery. Some people may have had several traumatic experiences, rather than one isolated incident, or the entire gestation period was one that was fraught with pain and discomfort (Bauchheimer, 1983; Haeslein, Niswander, 1980). I will explore some of the major issues and developmental periods and experiences that affect the unborn child, and therefore have impact upon the child at conception and for the rest of his or her life. For some people the issues described below emerge as a result of stress while for others they are repeatedly manifested. Patients will frequently express themselves metaphorically in regard to their birth first because of the energy that is tied to that dramatic and often traumatic experience (Grof, 1976; Janov, 1983; Laing, 1982). Individuals whose problems stem from prolonged or difficult labor may describe their life events as a series of "banging their head or themselves against a brick wall," or feeling that "there are no solutions" or "no way out" of life's problems. They tend to feel exhausted and battered from the ordinary efforts of daily living. Others may perceive that some force has always been pushing them, or that they have been perpetually stuck. They may want to run away, but they feel like "there is no place to go." That wonderful expression "caught between a rock and a hard place" frequently describes labor and pounding against the pelvic arch. We may all know people who experience themselves as being alone and lonely throughout their life. This is usually a result of the anesthesia used during delivery. As the anesthesia crossed the placental barrier, the unborn child along with the mother, became anesthetized. That experience became translated into "feeling drugged" or "stupid" throughout life. Mother's lack of ability to respond or assist at that time, later translated into "There was no one there to help me," "I have to do everything alone" or "I can't get through to you." At a another level, some people may feel they have difficulty in initiating activities or getting any momentum into their lives. They may feel out of touch with their feelings, environment, or professional or social life. Forceps-assisted deliveries occur more frequently than we may be aware. Often they result in patients having memories that are

best described as "being pulled in all directions at once," or "gripped or grabbed at by something vague and nameless." They may experience small confrontations as personal violations. Patients who perceive many situations as hopeless and therefore have a continuing need to be rescued, may have also been delivered by forceps. When involved in a complex or difficult task they tend to give up prematurely, rather than struggling and reaching a successful conclusion on their own. Often they complain if pressed to do things independently. People delivered by Caesarean section who have experienced a trial of labor, generally will be able to engage in complex tasks (English, 1985), but may have difficulty in the final details of the solution. These folks will stubbornly persist to the very end. Over and over again they need the satisfaction of "doing it by myself." When they do permit outside intervention into their territory, assistance is experienced as defeat and they feel that they lost or capitulated. Many born by nonlabor Caesarean section not only anticipate being rescued from ordinary life situations, but also tend to give up before they really have attempted to engage in a complicated task or put forth reasonable effort to solve problems. Since these individuals never have had the experience of struggling through labor, they never learned that they could successfully survive a struggle. For all of these populations, i.e. forceps-assisted and labor and nonlabor C-section deliveries, life in general is experienced as being torn by conflict with the unsavory choices of ambivalence and indecision. To the observer they appear to be helpless Victims in need of a Rescuer, while they often feel that they are Victims who are being Persecuted. (Berne, 1964; Karpman, 1968). All unborn children are subject to many influences. If mother had morning sickness then the hormones that affected her would have also affected the unborn child. As these hormones crossed the placental barrier the baby would have felt nausea too. As adults fleeting sensations of queasiness or nausea are abreactions to that fetal experience. Others that now have a transitory impaired sense of balance may be reflecting archaic movement or shifts in their positions in the amnion. Some adults may be seated or standing still and describe their stomachs as doing somersaults, or experiencing queasiness or a floating feeling, similar to that of an elevator dropping suddenly. These sensations do not relate to the objective observation of their environment or situation, nor does the lack of equilibrium have any current physiological basis. The expression "I don't know which way is up" often relates to issues around personal parameters and ego boundaries during gestation. The unborn child will find a favorite position in which to lie. However, if the baby tends not to move or stays in one position for a prolonged period of time, the result may be chronic cramping, pain, or damage to a portion of its body. Arms and legs that are held in a static position, or a baby that rests its head too long on its shoulder may experience repeated trauma to the vulnerable parts of the body, or illness such as bursitis or arthritis. As an example, a woman whose vulnerable site was her neck experienced whiplash from adolescence through adulthood, from minor diving, skiing, and auto accidents. Persons with this kind of background may refer to life or others as "a pain," or more specifically as "a pain in the neck." In the Peanuts cartoon by Charles Schultz, Linus portrays a familiar figure, one with whom many can identify. There are many families whose children cling tenaciously to a favorite blanket or cuddly toy, and grieve desperately when love, affection, and hard use reduce it to a few soiled and tattered shreds. What these babes have done is to transfer and maintain their emotional bond for their lost placenta and umbilical cord to their favorite toy or blanket. The language they choose to describe themselves focuses on having a part missing, lost or gone. When functioning poorly, "I guess I'm not all here today" sums up their perception of themselves. The first issues that relate to separation anxiety stem from the loss of the placenta and umbilical cord (Laing, 1976). For some bright optimistic individuals, they may typically view new beginnings as "It's a bright new world out there" or "Okay, let's make a fresh start." The problem with these sunnyside-up statements is that they may belie the current trauma and turmoil of their lives. Their Pollyannaish behavior is not congruent with the apparent need to solve the problems of daily living, but rather suggests that they deny issues. Scarlet O'Hara's "I'll think about it tomorrow" is another excellent example. With some others, the optimism is genuine; the period of gestation and delivery was relatively benign, loving and supportive. Therefore birth represented a healthy, natural, developmental progression. One that indeed represented a loving welcoming new beginning. In many families

the joy of the expectant mother in feeling life and fetal movements for the second half of the pregnancy is pleasurable and reassuring. There's a range of normal fetal activity as many women can attest to. They can compare their subsequent pregnancies and many years afterward are able to describe the different styles, types and frequencies of movement for each child that they bore. Some babies were free to be active and reactive to their internal needs and environment. When one mother attended a rock concert and the unborn baby was uncomfortable with the loud music and harsh rhythms the child actively made its discomfort known. Mother sensed her baby's agitation and left the concert. This woman understood and respected her baby's needs. Other babies may not have been so fortunate. The communication between mother and baby may have been clear, but not necessarily in the best interests of an unborn baby's psychological needs. For example mother's anxiety and general discomfort with being pregnant may have conveyed an articulate message that to minimize mother's anxiety, precious little movement from the baby would be tolerated. As a result the general physical movement of these now adult men and women may be lethargic or rigidly and tightly controlled. Common idioms are "don't rock the boat," and "Don't make waves." How clearly these words express precisely what they were not allowed to do. These people may be fearful of the water and never learn to enjoy water sports such as swimming, fishing or boating. The intrauterine temperature is about 100° Fahrenheit or 37° Celsius. Most delivery rooms are kept at approximately 68°F or 20°C, which means that the newborn infant may experience a dramatic drop in temperature. Some newborn babies become hypothermic and later perceive themselves as often "out in the cold." In a more relaxed time or era, prior to World War II, when a baby was delivered, the attending physician or midwife waited perhaps ten to twenty minutes for the baby to breathe fully, comfortably and independently. During this interval the umbilical cord would begin to atrophy. This served as an indication that the cord was no longer needed and could be cut. During World War II and the London Blitz, time was precious. A few moments during delivery often made the difference between safety and protection, or life and death. The practice of cutting the umbilical cord as soon after birth as possible became an expedient procedure. This along with the new mother becoming ambulatory, often within minutes or hours following delivery, changed what had been a ten day to two week lying-in period to the current practice of twenty-four hours or less. If there have been no complications the average mother is able to, with some assistance, assume a reasonable schedule at home. This enables her to regain her strength and energy more quickly. The baby too benefits from closer contact and continuation of the bonding with mother without the intervention of nursery staff and other professionals. It may have been expedient under war-time conditions to cut the cord quickly; that general practice continued and spread rapidly throughout the western world. The babies seemed to experience no apparent permanent, physical ill effects. However, as these infants grow and develop, a range of problems result from this practice. These individuals may experience anxiety and fear or have panic attacks when confronted with the possibility of asphyxiation. Some develop a tendency to hyperventilate when stressed or experience a stinging or burning sensation in their bronchi and lungs. Psychologically they feel as if they were cut off or emotionally separated from the rest of the world. Behaviorally they may interrupt or cut off their speech patterns so that most of their sentences are incomplete. Sometimes their style of speaking is clipped and staccato, much like a drill sergeant. Thoughts, ideas or words are left hanging and dangling. "Now just wait a minute" will be a common phrase. Others may become aggressive with their verbal behavior by interrupting or cutting off other people's conversations. Castration anxiety in both men and women is related to the premature cutting of the umbilical cord (Feher, 1981). Our awareness of the number of twin conceptions has increased with the use of ultrasound early in the first trimester. This has brought to our attention an awareness of a blighted twin with a healthy child coming to full term (Cassill, 1982). Some of the psychological issues, here again, result in a diminished sense of being complete and whole. A separateness that puts the surviving twin apart from others makes these individuals feel as though things and people will disappear. A lifetime may be spent looking and longing for someone or something to make them feel intact and complete. They may frequently experience a deep and painful sense of abandonment, when all evidence in their family and social

history is to the contrary. Frequently, an underlying sense of guilt that relates to their having survived the pregnancy, or perception that they were responsible for destroying their twin. Sometimes they become collectors of paired objects, such as pairs of bookends or vases, mirrored image paintings, or crafts, such as the South American mollas. In their speech, they may make reference to a spouse as my "better or other half." When the umbilical cord wraps itself around the unborn baby's neck, though slightly compressed the cord does not cause an actual cessation of oxygen, but it does reflect a real problem of anoxia. From the unborn baby's perspective the physical sensations will be of strangulation or suffocation while emotionally anticipating disaster. As adults, they may find it difficult to wear clothing that has straight, high or tight collars, such as turtle neck sweaters or starched shirts and ties. Metaphorically, these patients may have difficulty "spitting their words out," "choking on thoughts," or have words "get stuck in their throat." They view the world as a place where they "make do" with minimums. Life is a "half empty rather than half full glass," they keep an eye on the "hole" rather than the "donut." Most of us experience some pressure on the umbilical cord during the birth process and therefore have some temporary limitation in our oxygen supply. The panic that results lasts but moments and quickly recedes as the ability to breathe ensues. When there has been undue pressure on the cord for a prolonged period of time, these individuals may view many ordinary daily activities as life or death issues (Hull, 1983). Patients diagnosed with the affective disorders have a higher number of neural receptors in their skin, which accounts for greater peripheral neural sensitivity (Tessler, 1984). This does not preclude others from having issues that relate to peripheral neural development. Patients with this type of problem will describe themselves as experiencing things as "crawling on their skin," "being on pins and needles," "being thin skinned," or take the paranoid view of "there are eyes everywhere," because they literally feel that all eyes are on them. Some individuals are prone to having headaches. They may specifically describe pain that forms a band or ring around their head and crosses the forehead and temporal lobes. These patients often talk about "a gripping band of pain." This type of headache is a result of pressure from the cervical ring. The source of migraine headaches may stem from neural development, particularly that of the optic nerves and eye spots at age five weeks gestation (Moore, 1983). Patients describe this headache as "a sharp pain behind the eyes" or a feeling that "skyrockets are going off' in their heads. Photosensitivity will result from trauma during the next several weeks as the optic nerve develops. Headaches that are felt at the top of the skull or move from the back of the neck up over the top of the head, usually indicate stress as the neural tube develops. Trauma or stress that occurs between three to six weeks gestation, when the brain and central nervous system are beginning to differentiate, also contribute to these painful headaches. People will describe feeling like the "top of the head is open or ready to blow off." "Splitting headache" refers to lobe differentiation or corpus callosum development, which occurs at about eleven weeks gestation. Just prior to tissue differentiation, at about four to six days of gestation (Nilsson, 1966), some patients may describe themselves as feeling "like a blob." They may look or experience themselves as the Pillsbury Dough Boy. Some shift in body mass, which may or may not be related to weight gain, frequently will be the evidence of this prenatal developmental state in the adult patient. Following that stage of development, patients complain of "feeling empty" or having "a hollow sensation in the pit of the stomach." They have images of being tied up in knots, or feel as though they are caving or folding in. They may also experience difficulties in sustaining activities or dealing with the slightest disagreement or confrontation. The mildest question leaves them feeling like they acquiesced or "caved in." They also experience a fair amount of gastrointestinal difficulties, cramping, burning sensation, indigestion, or heartburn from a mild and bland diet. "I don't belong anywhere; I don't feel committed or attached to my life, . . . my career, . . . my family; I feel as though I've always drifted from place to place, . . . from job to job." These words clearly signify a lack of emotional bonding that should have occurred with the physical attachment during implantation. Adopted children strive for permanence in their adult primary relationships. They tend not to believe that their partner is fully committed to the relationship. Often they work vigorously to test and subsequently destroy an established bond; therefore re-enacting the breech in bonding that occurred during gestation. The embryo must

feel wanted, accepted and loved as it nestles in to physically attach and emotionally bond as it continues its growth and development. A trip through the fallopian tube, a comparable journey for the microscopic egg of thirty to forty miles, carries all the high drama of the movie Fantastic Voyage. The fertilized ovum will experience the cillia that line the tubes as fingers that grab. In therapy these patients will refer to the gravitational pull as "always getting sucked into something." They may also describe new experiences as having to "feel their way through them, . . . through therapy, . . . through life." Their general mode of behavior may be best described as tentative. These metaphors are some pertinent verbal and behavioral manifestations of pre and perinatal trauma that I've observed. What is needed currently is for other clinicians to join with me to pool our observations; correlate these to various developmental issues and thereby, expand our knowledge. As our data and theoretical knowledge grows, so can our effectiveness as clinicians in helping patients resolve their prenatal issues. SUMMARY When an individual has experienced pre and/or perinatal trauma the evidence of those experiences will manifest themselves at a neurotic or psychotic level. Both language and behavioral patterns serve as diagnostic cues to assist us in identifying gestational trauma. As we become more familiar with the symptomatic language of pre and perinatal issues and their developmental correlates, our skills in helping patients deal with these at an appropriate level are enhanced. This paper provides a comprehensive discussion of these metaphors, but it is in no way a complete list. By listening to our patients and sharing our knowledge, our understanding of this symbolic language will grow. References REFERENCES Berne, E. (1964). Games people play. New York: Grove Press. Buchheimer, A. (1983). Memory-preverbal and verbal. Paper presented at the meeting of the 1st International Congress of Pre- and Peri-Natal Psychology, Toronto, Ontario, July 1983. Cassill, K. (1982). Twins: Nature's amazing mystery. New York: Anthenum. English, J. (1985). Different doorway: Adventure of a caesarean born, California: Earth Heart. Fehrer, L. (1981). The psychology of birth. New York: Continuum. Grof, S. (1976). Realms of the human unconscious. New York: E.P. Dutton. Haeslein, H.L. and Niswander, K.R., (1980). Fetal distress in full term pregnancies. American Journal of Obstetrics and Gynecology, 137: 245-251. Hull, W.F. (1983). Prenatal oxygen deprivation: It's resultant life-long emotionality. Paper presented at the 1st International Congress of Pre- and Peri-Natal Psychology, Toronto, Ontario: July 1983. Janov, A. (1983). Imprints: The life long effects of the birth experience. New York: Coward-McCann, Inc. Karpman, S.B., (1968). Fairy tale and script drama analysis. Transactional Analysis Journal, 7(26): 26-42. Laing, R.D. (1976). Facts of life. New York: Panthenon Books. Laing, R.D. (1982). Voices of experience. New York: Panthenon Books. Moore, K.L. (1983). Before we are born: Basic embryology and birth defects. Philadelphia: W.B. Saunders. Nilsson, L. (1966). A child is born. New York: Delacorte Press. Tessler, S.R. (1984). "Study links depression to biological problems." The Detroit News, August 30, 1984. AuthorAffiliation Sandra G. Landsman, Ph.D. AuthorAffiliation Sandra G. Landsman, Ph.D., is a psychologist and healer in private practice in Jupiter, Florida. Address correspondence to the author at P.O. Box 7134, Jupiter, FL 33468-7134.

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